STATE OF CALIFORNIA
DEPARMENT OF INSURANCE
45 Fremont Street, 24th Floor
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UPDATED INFORMATIVE DIGEST

INDIVIDUAL DISABILITY POLICY LOSS RATIO REGULATIONS

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PROCEDURAL HISTORY

On July 21, 2006, the Department of Insurance gave notice of the proposed adoption of amendments to California Code of Regulations ("CCR") Title 10, Chapter 5, Subchapter 2, Article 1.9 ("Standards for Determining Whether Benefits of an Individual Hospital, Medical or Surgical Policy Are Unreasonable In Relation to the Premium Charged Pursuant to Subdivision (c) of Section 10293"), sections 2222.10, 2222.11, 2222.12, 2222.13, 2222.14, 2222.15, 2222.16, 2222.17, and 2222.19. The notice stated that the proposed regulation would significantly increase the loss ratio requirement for individual hospital, medical or surgical policies, describe the actuarial method by which the loss ratio is to be calculated, provide that the new loss ratio will apply to new policies and to existing policies on rate revision, include mass-marketed policies, delete an obsolete preliminary screening procedure and an obsolete table of credibility factors, and make other, non-substantive, changes.

On October 25, 2006, after considering public comments on regarding the proposed regulation, the Department of Insurance made available for public inspection certain changes to the regulation text as initially proposed. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. (Cal.Code Regs., tit. 1, §42.) The following informative digest has been updated to reflect these changes, and also revised for clarification in response to comments regarding the initial informative digest during the first public comment period.

UPDATE OF INFORMATIVE DIGEST

POLICY STATEMENT OVERVIEW

1) Purchasers of individual hospital, medical or surgical policies lack expertise and market power

One of the most significant factors facing purchasers of individual hospital, medical or surgical insurance is the disparity in expertise and market power between the purchaser and the insurer. While large purchasers of group health insurance have expertise in judging the level of benefit, and market power in negotiating benefits, small groups and individuals lack such expertise and

market power, even though they may have the benefit of the services of an insurance agent in selecting and purchasing their health insurance. In part as a result of this disparity, the market for individual insurance does not function at full efficiency. This disparity in market knowledge and market power accounts, in part, for the fact that the amount of premium remaining after benefits and expenses is significantly higher for individual hospital, medical or surgical insurance, as compared to group health insurance.

2) Purchasers of individual hospital, medical or surgical policies bear an increasing economic burden

Consumers who purchase individual hospital, medical or surgical insurance policies face a growing economic burden, as both premium costs and out-of-pocket expenses have significantly increased. This economic burden is consistent with larger trends in health care costs. In the past decades, health care spending in the United States has outpaced the general rate of inflation. Nationally, the amount spent per person on health care increased 74 percent between 1994 and 2004. In addition to the increase in health care costs, the nature of the expenses has changed over the past 20 years, shifting to areas for which the individual hospital, medical or surgical insurance policyholder often must pay a significant portion of the expense. Between 1984 and 2004, the amounts paid for prescription drugs, as a percentage of national health expenditures, increased from 4.9% to 10.0%. From 2001 through 2004, the average annual growth rate in national health care expenditures was 8.4 percent. In the California individual hospital, medical or surgical insurance market, premiums rose almost 40 percent between 1997 and 2002, in contrast to an approximately 12 percent rise in the prices of other goods and services, as measured by the Consumer Price Index, over the same period.

3) Purchasers of individual hospital, medical or surgical policies are a vulnerable population

While this environment of rising costs poses challenges for purchasers of individual hospital, medical or surgical insurance, additional factors make these purchasers particularly vulnerable. First, the individual hospital, medical or surgical insurance market is the last resort for many; California has a higher rate of persons without insurance and lower rates of employer-sponsored coverage than does the nation as a whole. In addition, the need for individual hospital, medical or surgical insurance has been increasing due to corporate downsizing. Those who are not fortunate enough to receive insurance through their workplace and are not eligible for public programs must attempt to obtain coverage in the individual market. Once covered by individual insurance, many consumers rely on maintaining that coverage for years. In California, the individual insurance market is an important source of long-term hospital, medical or surgical insurance coverage for a sizable fraction of those who purchase it.

A second factor that confronts purchasers of individual hospital, medical or surgical insurance policies is the fact that products in the individual market are difficult to qualify for because they are carefully underwritten to manage risk. A third factor is the rapidly increasing cost of individual insurance. High premiums and the low incomes of many of the potential purchasers of individual insurance makes affordability a particular concern. The increasing expense of individual hospital, medical or surgical insurance reduces affordability, which in turn reduces

availability for consumers who might otherwise be forced to go without vital hospital, medical or surgical insurance coverage. Also, inadequate benefits in individual insurance coverage can be a major source of underinsurance, which affects 13-20 percent of the privately insured. On average, coverage in the individual hospital, medical or surgical insurance market is less complete than coverage in the group market. Thus, purchasers of individual hospital, medical or surgical insurance are faced with rapidly increasing health care costs in general, as well as even more rapidly increasing premiums for individual coverage. Because they have no realistic alternative to individual coverage, such persons are at risk of being priced out of the individual insurance market, and joining the large number of uninsured Californians.

4) Conclusion

Over forty years ago, the Legislature recognized that the market for individual hospital, medical or surgical insurance would have to be supported by regulation in order to ensure that policyholders received a reasonable return in benefit for their premium dollar. This regulation increases the efficiency of the market for individual hospital, medical or surgical insurance. The statutory basis for this regulation, Insurance Code section 10293 (discussed below), provides that approval for a policy may be withdrawn if the benefits provided are unreasonable in relation to the premium charged. Since 1962, the standard for the reasonableness of the relationship between benefits provided and premium charged for most policies has been a minimum 50 percent loss ratio (calculated by dividing the benefits provided by the amount of premium charged). However the dramatic transformation of the health care market over the ensuing 44 years has made the 50 percent loss ratio an inadequate standard. Premiums have increased to the point where individual hospital, medical or surgical insurance has become a heavy economic burden even for those who pass medical underwriting. Increasing out-of-pocket expenses for copays, deductibles, and uncovered care add to this burden. In addition, the purchasers of individual hospital, medical or surgical policies often have no alternative, and lack expertise and market power. Because of these factors, the legislative mandate of a reasonable relationship between premium charged and benefits received requires that the loss ratio requirement be raised in order to support the individual hospital, medical or surgical insurance market and ensure that these consumers obtain fair value for their hospital, medical or surgical insurance dollars.

SUMMARY OF EXISTING LAW; EFFECT OF PROPOSED ACTION

Summary of Existing Law:

Insurance Code section 10293, originally enacted during the 1961 legislative session and as subsequently amended, requires, among other provisions, that the Insurance Commissioner withdraw approval of individual or mass-marketed policies of disability insurance "if after consideration of all relevant factors the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged." The same Insurance Code section also required that the Insurance Commissioner promulgate "such reasonable rules and regulations…as are necessary to establish the standard or standards by which the commissioner shall withdraw approval of any such policy." As a result, on November 30, 1962, the Insurance Commissioner ordered that a new Article 1.9, consisting of sections 2222.10 to 2222.19, be added to the California Administrative Code. This article adopted a "loss ratio" as the means to

determine whether the benefits provided by a policy were reasonable in relation to the premium charged. A loss ratio is a measure used by the actuarial profession to evaluate the reasonableness of the benefits provided by a hospital, medical or surgical policy. Here, the "loss ratio" is the ratio of incurred claims to earned premium over the lifetime of a block of insurance business.

As adopted in 1962, section 2222.12, "Standards of Reasonability," provided standards of reasonableness for the ratio of benefits to premium charged in hospital, medical, and surgical policies. These standards were a loss ratio of not less that 50 percent (for policies with annual premiums in excess of $7.50 per person), and 35 percent (for policies with annual premiums below $7.50 per person). Article 1.9 was subsequently amended in March 1978 to add a minimum loss ratio of 55 percent for Medicare supplement policies. In January 1983, Article 1.9 was further amended to set a revised loss ratio of 60 percent for Medicare supplement policies. However, the loss ratio standard for non-Medicare supplement individual group policies has remained at 50 percent for forty-four years.

The authority for the existing law, and for each of the proposed amendments, is Insurance Code section 10293. The reference is 10293.

Effect of Proposed Action:

The specific proposed amendments and their effect are discussed below.

Section 2222.10. Applicability.

The amendment deletes the obsolete 1962 operative date for the regulation, and instead makes the amended regulation applicable to new hospital, medical or surgical policies delivered or issued on or after July 1, 2007. The proposed amendment to section 2222.10 also provides that the increased loss ratio established by this amended regulation will apply to existing policies subject to a rate revision effective on or after July 1, 2007.

Section 2222.11. Definitions.

Subdivision (a):

The existing subdivision provided a definition of the term "hospital, medical, or surgical policy." This definitional subdivision was included as a part of the original regulation when it first went into effect in 1962.

This definitional subdivision was included as a part of the original regulation when it first became effective in 1962. The purpose of the amendment originally proposed for this section was to clarify the definition by harmonizing it with subsequent statutory enactments. For example, in 1981 Insurance Code section 10293 was amended to include mass-marketed policies within the category of policies covered by that section. The proposed amendment incorporates the 1981 revision of section 10293 into the definition of "hospital, medical or surgical policy."

The originally proposed amendment also incorporated Insurance Code section 106(b), which was

amended in 2001 to provide a definition of "health insurance.' The purpose of including the definition contained in Insurance Code section 106(b) was to clarify that, for the purposes of this regulation, the term "hospital, medical, or surgical policy" includes all policies covered by the definition in Insurance Code section 106(b).

In response to comments received in response to the proposed amendment, section 2222.11(a) has been revised to exclude from definition of "hospital, medical, or surgical policy" supplemental policies of individual health insurance that provide coverage for vision care expenses only, dental care expenses only, or short-term limited duration health insurance with coverage durations of 6 months or less. Comments expressed concern that such policies cover limited types of benefits, are not meant to substitute for comprehensive hospital, medical, or surgical policies, and are sold at a low premium. Because of the low premium, comments expressed concern that such policies could not sustain a 70% loss ratio. After considering these comments, the commissioner concluded that these policies should remain at the current 50% loss ratio. The definition of "hospital, medical, or surgical policy" in section 2222.11 was therefore changed to exclude these policies from the definition, so that they could be treated separately in the subsequent section, 2222.12, that discusses standards of reasonability.

New subdivision (f):

The existing regulation was applicable to policies issued after July 1962, but did not apply to policies in force as of that effective date.

The proposed amended regulation includes a provision that the increased loss ratio requirement will apply to existing policies upon rate revision (as well as to new policies) after the proposed effective date, July 1, 2007. Subdivision (f) provides a definition of "rate revision." The definition provides that a "rate revision" occurs when premium rates change.

New subdivision (g):

The existing regulation, at 2222.12, describes the loss ratio calculation, but does not do so using current actuarial terminology.

The definition provided in this new subdivision (g) specifies the factors included in the calculation of a lifetime anticipated loss ratio, and the method of calculation, using current actuarial terminology.

New subdivision (h):

Based on consideration of comments received, the commissioner has determined that disease management expenses should, if the insurer wishes to do so, be included in the calculation of whether the benefits provided under a policy are reasonable in relation to the premium paid. Disease management expenses involve services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications using guidelines and patient self-management strategies. Disease management services, as described, can improve the health of insured, and can therefore reduce claims, and therefore the overall cost of health care.

Because of these benefits, the commissioner has determined that disease management expenses may be calculated as part of the determination of reasonability. The revised subdivision (h) provides a definition of "disease management expenses," based on Health & Safety Code section 13990.901.

New subdivision (i):

This new subdivision provides definition and method of calculation for a "lifetime anticipated disease management ratio." This definition parallels the definition and calculation method of "lifetime anticipated loss ratio" provided in subdivision "g," and uses the same accepted actuarial principles and calculation method used in the definition of "lifetime anticipated loss ratio." The use of an actuarial lifetime anticipated calculation is used because such a calculation method provides the fairest evaluation of the expenses over the lifetime span of an insurance product. The "lifetime anticipated disease management ratio" is defined separately from "lifetime anticipated loss ratio" because the disease management factor is used as a separate factor, at the option of the insurer, in the determination of compliance with the standards of reasonability provided in revised section 2222.12

Section 2222.12. Standards of Reasonability

As described above under "Summary of Existing Law," the existing regulation provides for a minimum loss ratio of 50% for individual hospital, medical, or surgical policies with annual premiums in excess of $7.50 per person, as well as other loss ratios for policies with lower annual premiums, and for Medicare supplement policies.

The proposed amended regulation changes the minimum loss ratio level at which non-Medicare-supplement hospital, medical, or surgical policies will be deemed to be reasonable from 50 percent to 70 percent.

The proposed amended regulation clarifies that the minimum loss ratio of 70 percent is calculated as a "lifetime anticipated" loss ratio. A "lifetime anticipated" loss ratio considers both the actual and anticipated experience over the anticipated lifetime of an insurance product in a way that takes into account random annual fluctuations in earnings and claims, as well as the fact that loss ratios during the early years of a policy are expected to be lower than loss ratios during the policy's later years. The lifetime loss ratio incorporates both the historical and anticipated performance of a given policy, and so provides the fairest picture of the design of the insurance policy in terms of how well it will deliver benefits to the consumer.

Further, in order to confer this reasonable level of benefit on both new policyholders and current policyholders (who often have no other realistic coverage options), the proposed regulation applies the 70 percent loss ratio requirement to new policies, and also to existing policies that file for rate revision. The proposed amended regulation requires that, upon the filing of a rate revision, the policy must demonstrate both a 70 percent lifetime loss ratio for the entire life of the product, as well as a 70 percent loss ratio for the period for which the amended rates are computed. The revised proposed amendment clarifies that the current 50 percent loss ratio continues to apply to existing policies for which no rate revision is sought. Also, the revised

proposed amendment provides that the insurer may, at its option, include disease management expenses in demonstrating compliance with the standard of reasonability.

In response to comments received during the public comment period regarding the effect that a 70 percent loss ratio might have on supplemental, non-comprehensive policies that provide coverage for limited types of health expenses (vision-only, dental-only, and short-term limited duration health insurance), the Commissioner has determined that the loss ratio for such policies should remain at the current 50 percent level.

The proposed regulation deletes the provision of the 1962 regulation that provided for a 35 percent loss ratio for policies with an annual premium of less than $7.50 per person. There are no longer any policies available at that premium rate, and so this provision is now surplus.

The proposed regulation also modifies the reference to loss ratios for policies designed to supplement Medicare. This provision was added in 1978, and amended in 1983, on both occasions specifying a specific loss ratio amount. In 2000, Insurance Code section 10192.14 was enacted, specifying a loss ratio amount for policies designed to supplement Medicare. The proposed amendment of the regulation incorporates Insurance Code section 10192.14(a)(1)(A) by reference, rather than stating a loss ratio amount. The effect of this amendment will be that the regulation will automatically incorporate any change in the loss ratio amount without need for further revision, should Insurance Code section 10192.14 be amended.

Section 2222.13: Preliminary Screening Procedure.

Insurance Code section 900 provides that insurers must file an annual statement with the department. The existing regulation provides for a preliminary screening of policies based on national data obtained from this annual statement (specifically, the accident and health policy experience exhibit of the annual statement blank promulgated by the National Association of Insurance Commissioners ["NAIC"]). However, effective as of 2007 for reports reflecting 2006 data, this NAIC experience exhibit will change from requiring that data be reported based on policy forms to, instead, requiring that data be reported based on type of business. Therefore, the experience exhibit will no longer contain the information needed for the implementation of the existing preliminary screening procedure described by existing section 2222.13. Thus, the proposed amended regulation deletes this entire section.

Section 2222.14: Credibility Factors.

Credibility factors are an actuarial means of determining whether deviation from a standard may be due to chance variation; for example, an insurance product in which relatively few policies have been sold would ordinarily be expected to show more deviation due to chance variation than would an insurance product with a large number of outstanding policies. The existing credibility factor provision dates back to 1962, and is based solely on premium volume figures that are outdated. The proposed amended provision provides that the commissioner may consider a broader set of credibility factors, not merely limited to premium volume, in recognizing deviations due to chance variation.

Section 2222.15. Communication to Insurer.

The proposed changes to this section involve a minor punctuation change that does not alter the substantive meaning of the section. The proposed change is to add a comma after "2222.17" in the introductory clause, as follows: "Prior to taking any action under Section 2222.17, the commissioner will…"

Section 2222.16. Consideration of Relevant Factors.

The proposed changes to this section involve deleting the provision regarding "policies issued on an industrial debit basis" as such policies are no longer issued, so these provisions are now superfluous.

Section 2222.17. Notice to Insurer.

The proposed amendments to this section are to enhance readability and clarity, and to substitute gender-neutral terms, and do not represent a substantive change from the existing regulation, as follows: The existing text:

"He shall further advise the insurer that unless within 31 days from the date thereof the insurer has committed itself in writing to the commissioner that it will, within 90 days thereafter, voluntarily either cease further issuance of the policy form or increase benefits under the policy in relation to premiums charged therefor sufficiently that they are reasonable in relation to such premiums, then the commissioner will thereafter, at his discretion, commence proceedings for the withdrawal of authorization of the form after notice and hearing as provided by law. At any time after expiration of said 31 days so specified, and if the insurer has not so committed itself to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings as provided by law for withdrawal of the authorization of the policy form,"

is replaced by

"The commissioner shall also advise the insurer that the commissioner will, at the commissioner's discretion, commence proceedings for withdrawal of authorization of the form after notice and hearing as provided by law unless, within 31 days from the date of the notification, the insurer commits itself in writing to the commissioner that it will, within 90 days, voluntarily either (1) cease further issuance of the policy form or (2) increase benefits under the policy in relation to the premiums charged in an amount sufficient to bring the policy into compliance with the minimum loss ratio standards provided for in section 2222.12. If the insurer does not commit itself, within 31 days from the date of the notification, to discontinue issuing the policy or increase benefits under the policy in relation to premiums charged, the commissioner may commence proceedings at any time as provided by law for withdrawal of the authorization of the policy form."

Section 2222.19. Filing Experience Data

Comments received during the public comment period expressed concern that, effective in 2007, the Accident and Health Experience Exhibit to the Annual Statement, filed by insurers in response to other statutory and regulatory requirements (e.g., Insurance Code section 900), will no longer identify experience by policy form, and so would not provide the information needed to demonstrate compliance with the standard of reasonability. (The Exhibit and the Annual Statement are forms developed and revised by the National Association of Insurance Commissioners.) Accordingly, the revised regulation replaces the now-obsolete form reporting requirement with an updated and simplified report of loss ratios per policy form, supported by a certification by an actuary plus an optional schedule of disease management expenses if an insurer chooses to include such expenses in demonstrating compliance with the standard of reasonability.

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